

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN 1b 1 hr. 35 min. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. Va. b. COUNTY Kanawa c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ru ral - Charleston d. STREET ADDRESS Route #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Thomas Last Akers		4. DATE OF DEATH October 23rd. Month 19 Day 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-1917 9. AGE (In years last birthday) 49 IF UNDER 1 YEAR: Months 49 Days 49 Hours 49 Min. 49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Raleigh Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William F. Akers		14. MOTHER'S MAIDEN NAME Lillian Kirk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-26-5089	
17. INFORMANT William G. Akers, (Son)		Address W. Va. Charleston,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary sclerosis (b) Coronary sclerosis DUE TO 4201 (c) Coronary sclerosis		INTERVAL BETWEEN ONSET AND DEATH Hours Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Previous myocardial injury		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr., M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 10-23-66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/25/66	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) South Charleston, W. Va.
24. FUNERAL DIRECTOR John O. Durst LEIGHTON-DURST FUNERAL HOME, Oakland, Md.		25a. REC'D BY REGISTRAR Charles Judge DATE OCT 28 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14189 CERTIFICATE OF DEATH 14189											
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bittinger 11-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital						d. STREET ADDRESS Bittinger					
3. NAME OF DECEASED (Type or print) First Clarence Middle Brenneman Last Brenneman						4. DATE OF DEATH Month October Day 24 Year 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-8-82		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR FUND 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11. BIRTHPLACE (County & State, or foreign country) Bittinger, Maryland				12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Joel J. Brenneman						14. MOTHER'S MAIDEN NAME Katherine Bittinger					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. ---		17. INFORMANT Frank Brenneman, Bittinger Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE BRAD VASCULAR ACCIDENT 331X DUE TO (b) ADVANCED CEREBRAL ARTERIO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from October 20 , 19 66 , to October 24 19 66 , that (I) (two) last saw the deceased alive on October 24 19 66 , and that death occurred at 1:35 PM from the causes and on the date stated above.											
22a. SIGNATURE Dr. E. I. Baumgartner						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/24/66			
22c. PHYSICIAN'S NAME (Type) Dr. E. I. Baumgartner						22d. ADDRESS Oakland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
Burial		10/27/66		BITTINGER		BITTINGER GARRETT Co. Md					
24. FUNERAL DIRECTOR Don Newman, Grantsville, Md.						25a. REC'D BY REGISTRAR OCT 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14190

14190

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARTIN Middle VAN Last BROWNING				4. DATE OF DEATH Month October Day 30 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 6, 1904	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Dealer				10b. KIND OF BUSINESS OR INDUSTRY Junk		11. BIRTHPLACE (State or foreign country) Deer Park, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel S. Browning				14. MOTHER'S MAIDEN NAME Anna M. Grimm			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 212-16-0439		17. INFORMANT Address (Widow) Mrs. M.V. Browning, Deer Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Arteriosclerosis, generalized DUE TO (c) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James H. Feaster, Jr., M.D.				22. DATE SIGNED 10-31-66			
EXAMINER'S NAME (Type)				Address (Street, city, town, or county) Oakland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/66		23c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		23d. LOCATION (City or Town) (County) (State) Deer Park, Maryland	
24. FUNERAL DIRECTOR John O. Durst Leighton-Durst Funeral Home, Oakland, Md.				25a. REC'D BY REGISTRAR NOV 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1419A

14191

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN lb 1 Day 21 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHALLMAR			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS 11-1			
3. NAME OF DECEASED (Type or print) DOLLY MAE COAN				4. DATE OF DEATH October 12 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/1900	9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Kitzmillers, Garrett, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Forrest Bernard				14. MOTHER'S MAIDEN NAME Mary Jane Tasker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-52-9783		17. INFORMANT Address Elva Stonebraker			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis 4221 DUE TO 4 Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 week DUE TO (c) Arteriosclerotic Cardio Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 4 days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 9, 1966 to October 12 1966 , that (I) (we) last saw the deceased alive on October 12 1966 , and that death occurred at 7:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Robert H. Leighton				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12 Oct 66	
22c. PHYSICIAN'S NAME (Type) Dr. H. H. Leighton				22d. ADDRESS Oakland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-15-66		23c. NAME OF CEMETERY OR CREMATORY Methoden Hill Cemetery		23d. LOCATION (City, town or county) (State) Elk Garden W Va.	
24. FUNERAL DIRECTOR Robert Kyle Britha Jr.				ADDRESS Kitzmillers, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 40 minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Woodrow Davy		4. DATE OF DEATH October 20 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1912
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		12. KIND OF BUSINESS OR INDUSTRY Plumbing	
13. BIRTHPLACE (State or foreign country) Hampshire Co., W. Va.		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME Charles A. Davy		16. MOTHER'S MAIDEN NAME Rosa L. Shears	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW 2		18. SOCIAL SECURITY NO. 705-05-9327	
19. INFORMANT Mrs. Viola Davy		Address see #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis, acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4201 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr., M.D.		22. DATE SIGNED 10-20-66	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.		Address (Street, city, town, or county) Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/22/66	
23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION (City or Town) (County) (State) Oakland Maryland	
24. FUNERAL DIRECTOR Gerald D. Minnick		25a. REC'D BY REGISTRAR Oakland, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 24 1966	

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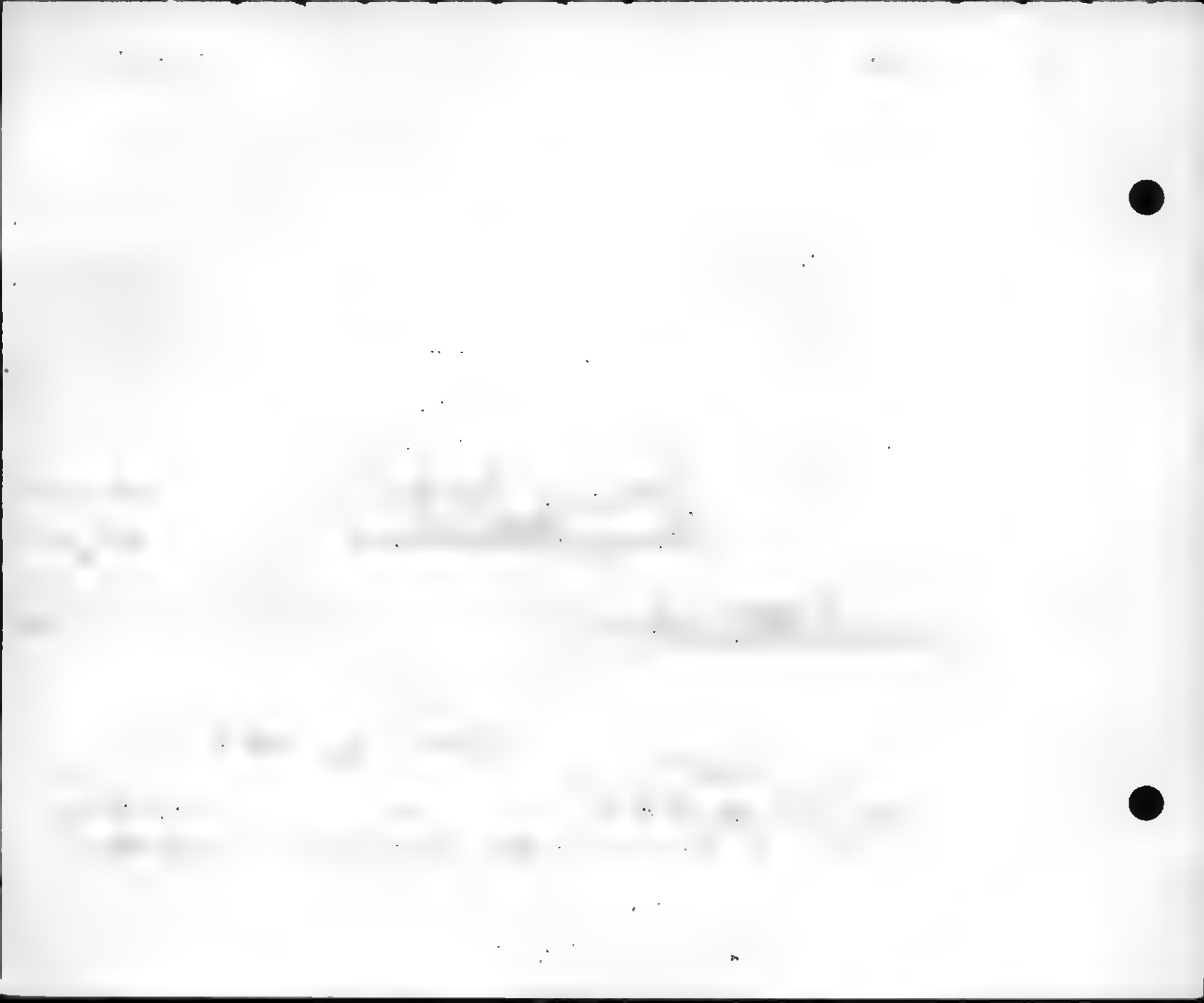
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11-93 Item #1d Film #332 10/25/66
CERTIFICATE OF DEATH 14193

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Grantsville</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Grantsville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Star Route (home of Daughter)</u>			d. STREET ADDRESS <u>11-1</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret L. Engle</u>			4. DATE OF DEATH Month Day Year <u>Oct. 19</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1913</u>	9. AGE (in years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Bromsgrove, England</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			12. CITIZEN OF WHAT COUNTRY? <u>XXXXXX USA</u>		
13. FATHER'S NAME <u>Benjamin Lidell</u>			14. MOTHER'S MAIDEN NAME <u>Emily Collins</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>--</u>		
17. INFORMANT <u>Mrs. Grace Garlitz, Grantsville, Md.</u>			Address		

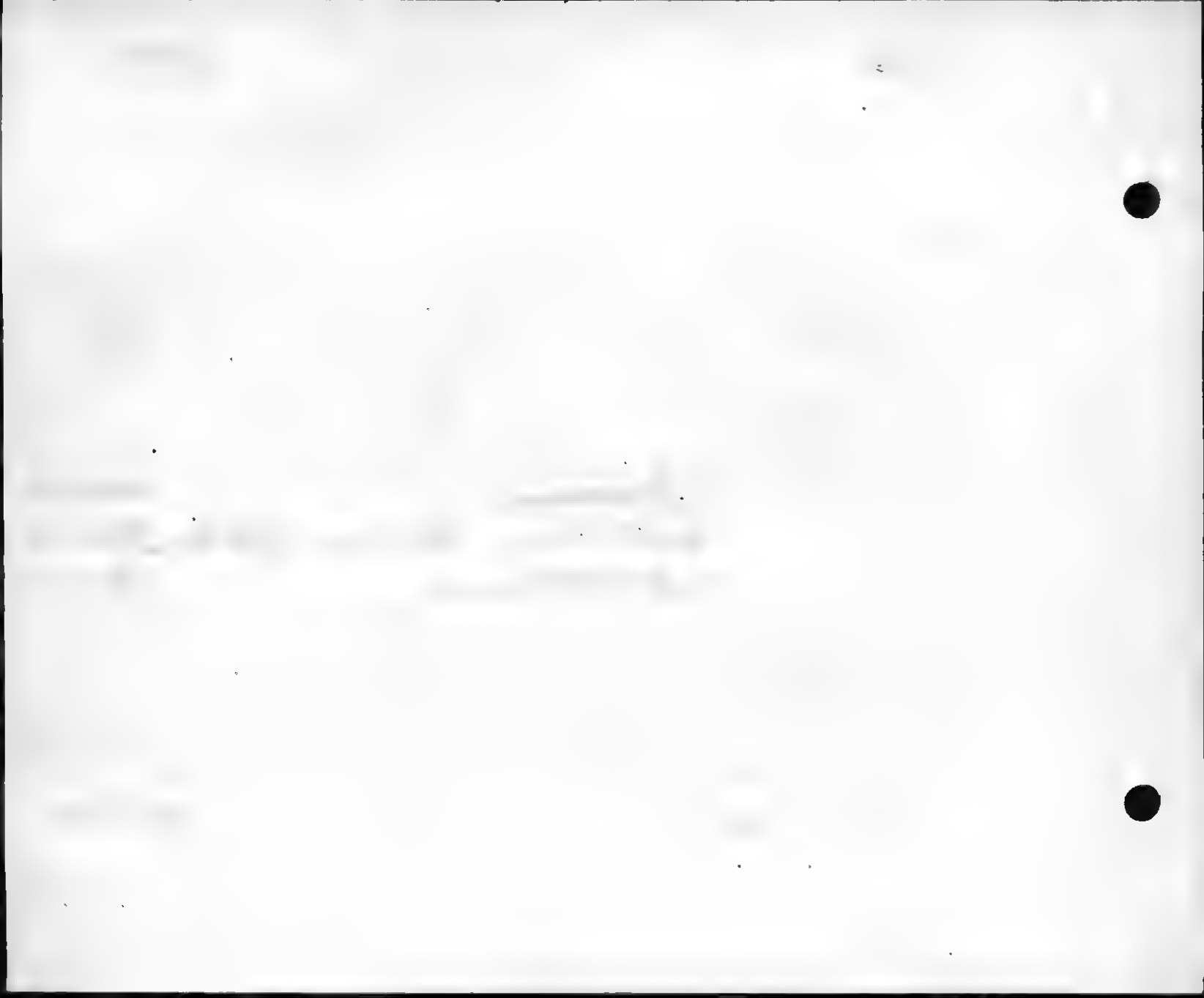
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>sw. years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1962</u> , to <u>Oct 6, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 26 1966</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul E. Berkebile</u>						22b. DATE SIGNED <u>10/8/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL E. BERKEBILE MD.</u>						22d. ADDRESS <u>349 MAIN ST., MEYERSDALE, PA.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/9/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Church Cem. R.D., Meyersdale, Somerset, Pa.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Ruth E. Newman</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
ADDRESS <u>Grantsville, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>OCT 11 1966</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The **1** requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. **1** and **2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH **14194**

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN 1b <u>4 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accident</u> 11-1 d. STREET ADDRESS <u>Rt. 2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Loa</u> Middle <u>Elnora</u> Last <u>Glover</u>		4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>19 66</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <u>9-15-90</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months <u>11</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Keyser Ridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>James Kelso</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Platter</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>Clyde Glover, Accident, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral</u> 142 X DUE TO <u>Cardio-renal disease & failure</u> 10 days (b) <u>Arteriosclerosis</u> 7 yrs (c) <u>Arteriosclerosis</u> 7 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 21, 19 66</u> to <u>OCTOBER 25, 19 66</u>, that (I) (we) last saw the deceased alive on <u>October 25, 19 66</u>, and that death occurred at <u>8:40 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Dr. A. E. Mance</u>				22b. DATE SIGNED <u>25 Oct 66</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. A. E. Mance</u>		22d. ADDRESS <u>Oakland, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/28/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Addison, Pa. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Addison, Somerset, Pa.</u>					
24. FUNERAL DIRECTOR <u>Don Newman</u>				25a. REC'D BY REGISTRAR <u>Grantville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles [unclear]</u>					

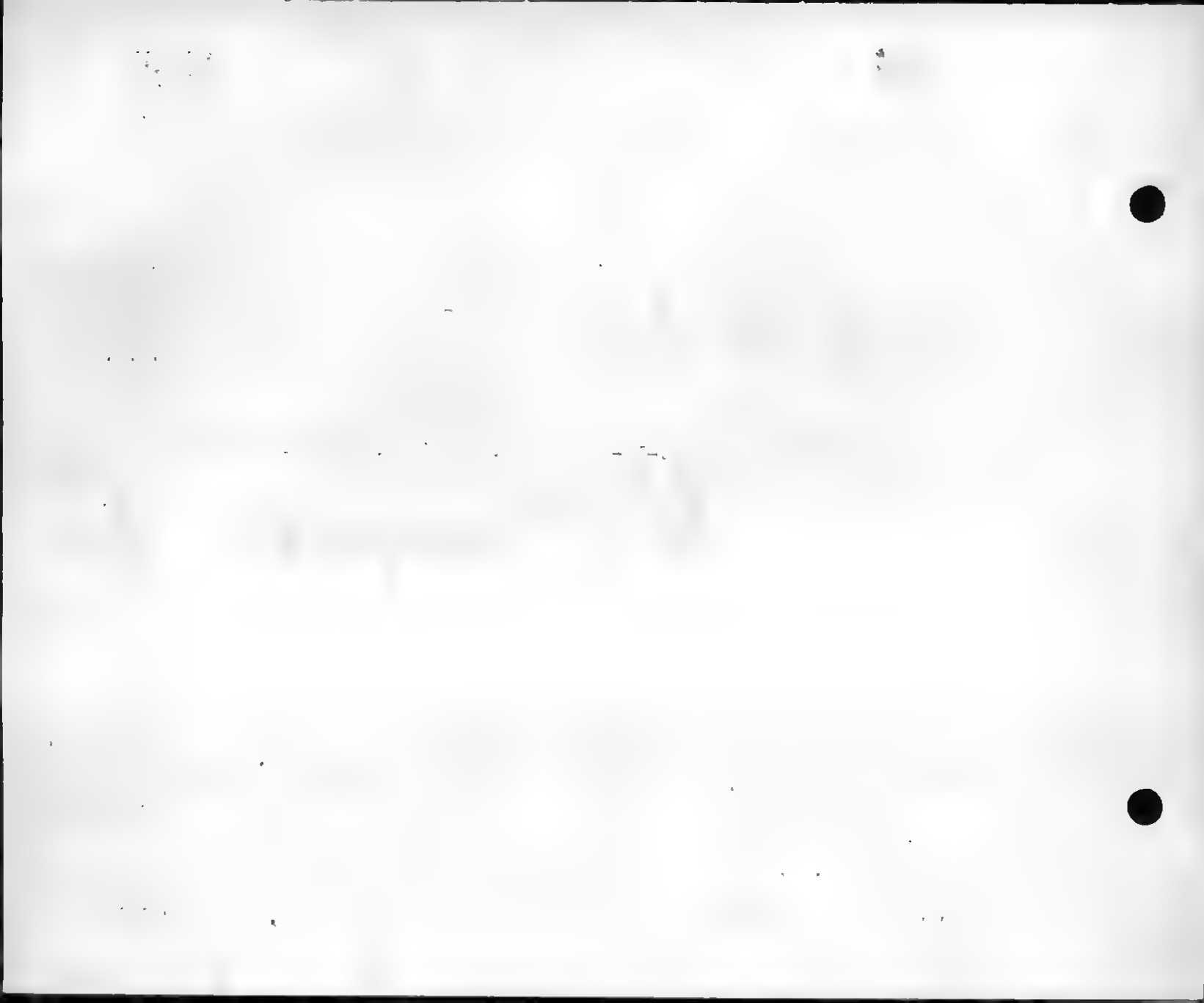


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 14195

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PRESTON			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN ID 4 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EGLON F5-3			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett County Memorial Hospital				d. STREET ADDRESS Box 258		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES First NELSON Middle HARSH Last		4. DATE OF DEATH October 4 1966		5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-12-82		9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) PRESTON, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LLOYD HARSH				14. MOTHER'S MAIDEN NAME MARY COLEMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 232-10-3660		17. INFORMANT Mrs. Melvin R. Harsh - Daughter in Law			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Chronic Pyelonephritis DUE TO (c) Chronic Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 wk 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/1 1966 to Oct. 4 1966 , that (I) (we) last saw the deceased alive on Oct. 4 1966 and that death occurred at 1:57 AM from the causes and on the date stated above.							
22a. SIGNATURE <i>A. E. Mance</i>				22b. DATE SIGNED 5 Oct 66		22c. PHYSICIAN'S NAME (Type) A. E. MANCE	
22d. ADDRESS Oakland, Maryland				22e. ADDRESS Oakland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/1966		23c. NAME OF CEMETERY OR CREMATORY Eglon Cemetery		23d. LOCATION (City, town or county) (State) Eglon, West Virginia	
24. FUNERAL DIRECTOR <i>Arthur K. Finkle</i>				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

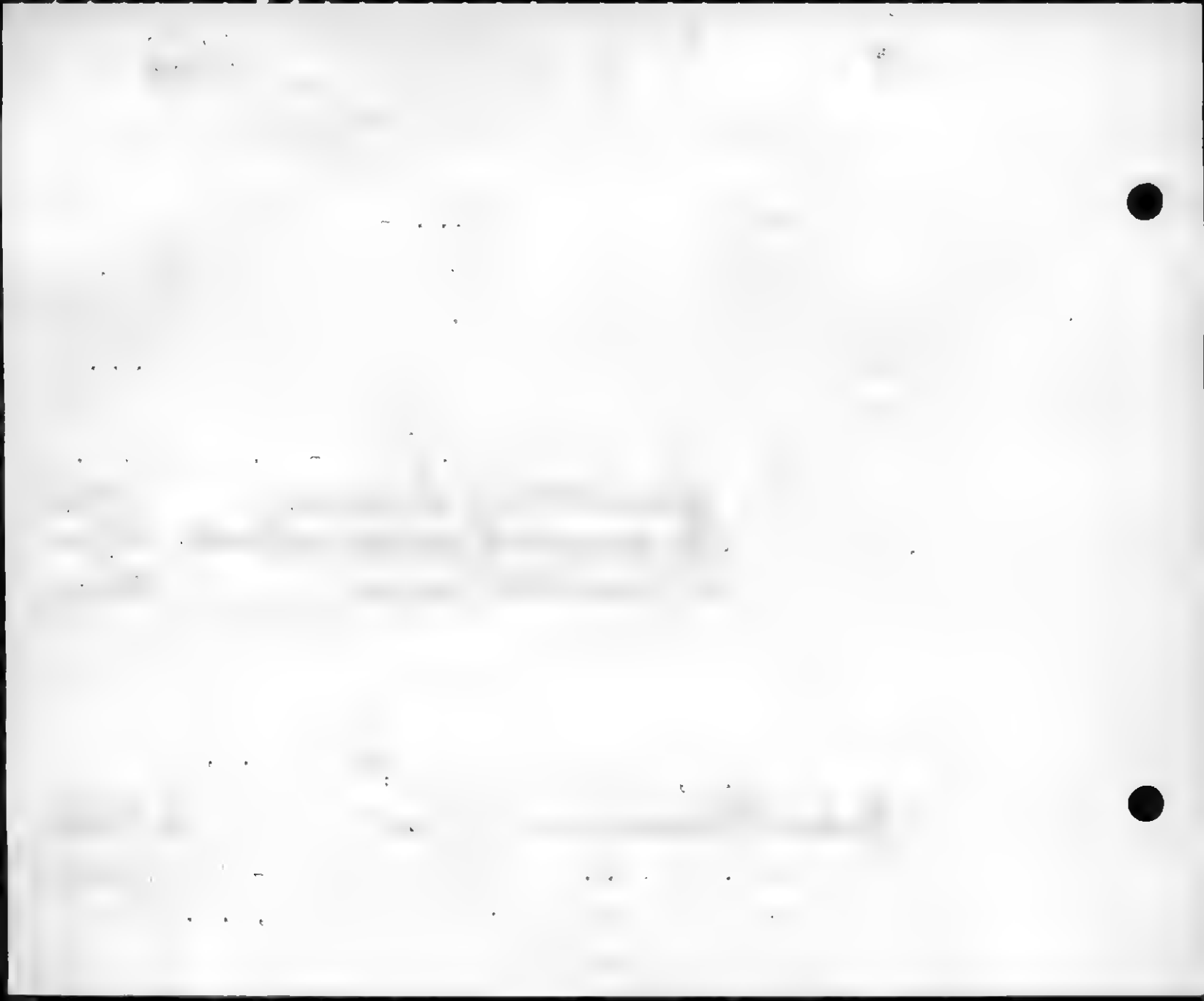


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND c. LENGTH OF STAY IN 1b 25 da ys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND d. STREET ADDRESS P.O. - BOX # 223 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORA Middle ELLEN Last HENLINE		4. DATE OF DEATH Month OCTOBER Day 15 Year 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 14, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77 yrs.
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL CALHOUN		14. MOTHER'S MAIDEN NAME LAURA HARSH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT (D-IN-LAW) HELEN M. HENLINE - MT. LAKE PARK, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - Terminal DUE TO (b) Arteriosclerosis DUE TO (c) Chronic Sclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH 2 Days 5 yrs - 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to OCT. 15, 1966 , that (I) (we) last saw the deceased alive on OCT. 15, 1966 , and that death occurred at 4:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE Andrew E. Mance		22b. DATE SIGNED 16 Oct 66	
22c. PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		22d. ADDRESS THIRD STREET - OAKLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/1966	
23c. NAME OF CEMETERY OR CREMATORY Egdon Cemetery		23d. LOCATION (City, town or county) (State) Egdon, W. Va.	
24. FUNERAL DIRECTOR Dexter R. Finkle Davis		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE OCT 20 1966	

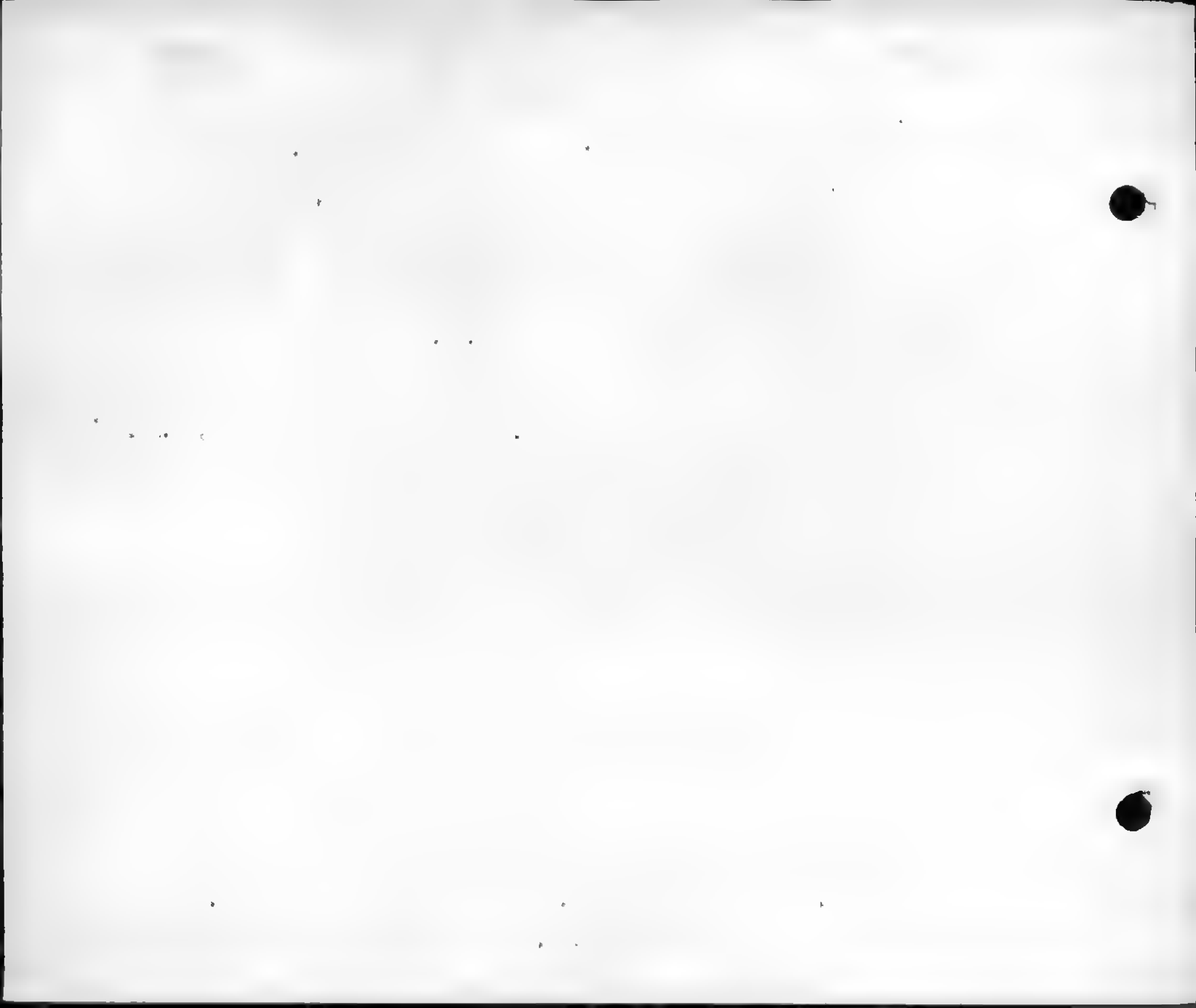


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14197

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garland c. LENGTH OF STAY IN 1b 11 Mos. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Week's Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport, Md. d. STREET ADDRESS Maryland Ave. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dean Middle LAUDON Last Moorehead		4. DATE OF DEATH Month Oct. Day 6 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1884
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oliver Kight		14. MOTHER'S MAIDEN NAME Elmira Barriks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Melvin Moorehead		17a. ADDRESS 1377 Cornell St. Keyser, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Arteriosclerosis (b) Arteriosclerosis DUE TO Arteriosclerosis (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia		INTERVAL BETWEEN ONSET AND DEATH no mos years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 6 19 1966 , to Oct 11 19 1966 , that (I) (we) last saw the deceased alive on Oct 6 19 1966 , and that death occurred at 6 p M, from the causes and on the date stated above.			
22a. SIGNATURE B. L. Grant		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) B. L. Grant M.D.		22d. ADDRESS Oakland, Md.	
23a. BURIAL CREMATION, (Specify) Burial		23b. DATE THEREOF Oct. 9, 1966	
23c. NAME OF CEMETERY OR CREMATORY Philos Com.		23d. LOCATION (City, town, or county) (State) Westernport, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. B. C.		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE OCT 10 1966			



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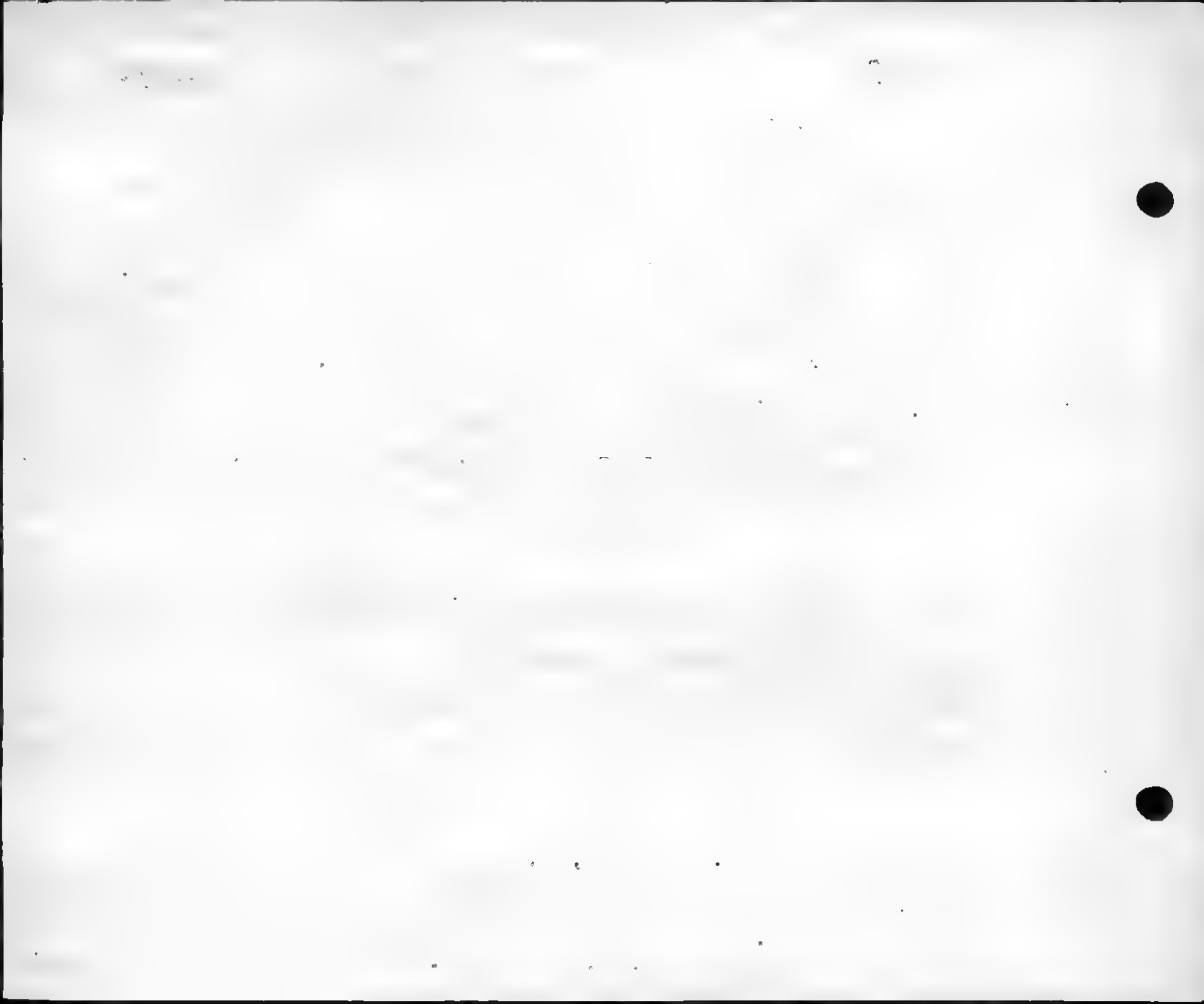
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14198

1 PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Garrett</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Oakland</u>		c LENGTH OF STAY IN TB <u>46 yrs</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route #1</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>RUSSELL</u> <u>WARLAND</u> <u>LEIGHTON</u>		4. DATE OF DEATH Month Day Year <u>October</u> <u>21</u> , 19 <u>66</u>	
5 SEX <u>Male</u>	6 CO. OR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 23, 1900</u>
9 AGE (n years last birthday) <u>66</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Dealer</u>	10b KIND OF BUSINESS OR INDUSTRY <u>Auto Garage</u>
11. BIRTHPLACE (County & State or foreign country) <u>Garrett Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>R. Oliver Leighton</u>		14. MOTHER'S MAIDEN NAME <u>Laura Sine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>212-32-8260</u>	
17 INFORMANT <u>Mrs. Laura Leighton, Et 1, Oakland, Md.</u>		Address (widow)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <u>Acute Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO <u>Acute Myocardial Infarct</u> (c) <u>Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>54</u> to <u>Oct 24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 16</u> , 19 <u>66</u> , and that death occurred at <u>7:15 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Herbert H. Leighton</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>25 Oct 66</u>
22c. PHYSICIAN'S NAME (Type) <u>Herbert H. Leighton, M.D.</u>		22d. ADDRESS <u>Oakland, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/26/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Oakland, Maryland</u>
24 FUNERAL DIRECTOR <u>John O. Durst</u> <u>Leighton-Durst Funeral Home, Oakland, Md.</u>		25a. REC'D BY REGISTRAR <u>John O. Durst</u> DATE <u>OCT 28 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14199

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Grantsville (Rural)		c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md.		b. COUNTY Garrett		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville (Rural)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Otto Merrbach		First		Middle		Last		4. DATE OF DEATH Oct. 3, 1966		Month		Day		Year	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/1/1896		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former				10b. KIND OF BUSINESS OR INDUSTRY Own Farm				11. BIRTHPLACE (County & State, or foreign country) Frostburg, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Merrbach								14. MOTHER'S MAIDEN NAME Annie Bowers							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 217-09-9036				17. INFORMANT S. Francis Merrbach, R.D. Grantsville, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis, Non-Rheumatic in origin DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerotic degenerative disease Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Valvular insufficiency												INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-26, 1965, to 10-3, 1966, that (I) (we) last saw the deceased alive on 10-3, 1966, and that death occurred at 7 AM, from the causes and on the date stated above.															
22a. SIGNATURE Grant Atwell												22b. DATE SIGNED 10-8-66			
22c. PHYSICIAN'S NAME (Type) Grant Atwell												22d. ADDRESS Meyersdale PA			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/9/66				23c. NAME OF CEMETERY OR CREMATORY Merrbach Cemetery				23d. LOCATION (City, town or county) (State) R.D. Grantsville, Garrett, Md.			
24. FUNERAL DIRECTOR Ruth E. Neuman				25a. REC'D BY REGISTRAR OCT 11 1966				25b. REGISTRAR'S SIGNATURE Charles Judge							

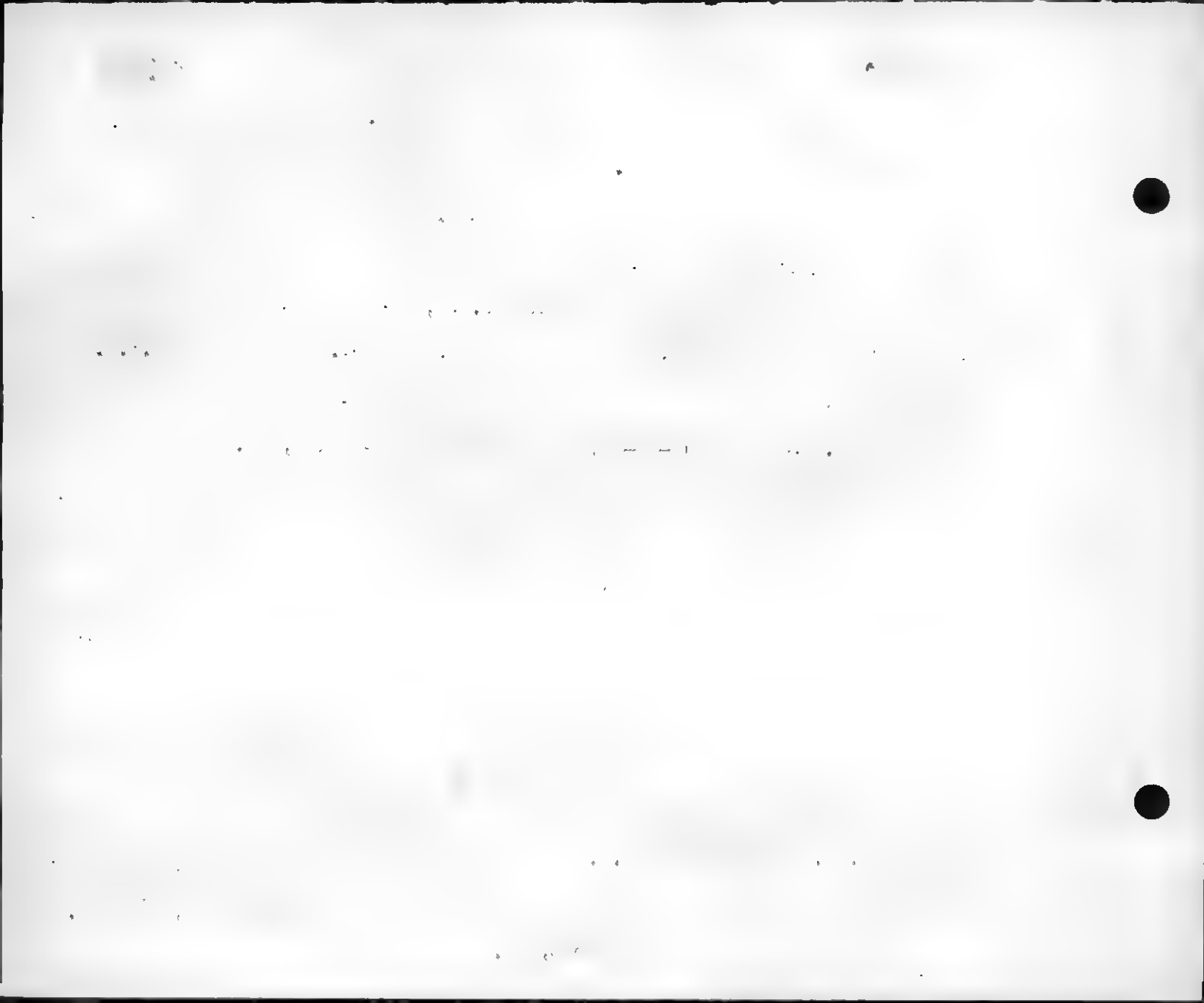
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14200

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Barton c. LENGTH OF STAY IN 1b Min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Barton d. STREET ADDRESS Railroad 6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle SAMUEL Last NEAT		4. DATE OF DEATH Month OCT. Day 12 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1923 9. AGE (In years last birthday) 43 yrs. IF UNDER 1 YEAR: Months 43 Days 43 Hours 43 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar tender		10b. KIND OF BUSINESS OR INDUSTRY Tavern	11. BIRTHPLACE (State or foreign country) Barton, Md. 12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Samuel Neat		14. MOTHER'S MAIDEN NAME Mary Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war & dates of service) W.W. 2		16. SOCIAL SECURITY NO. 214-16-2770	17. INFORMANT Address RoseMary Neat-Barton, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage, Maceration of Brain Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO Gunshot of Head DUE TO (Self Inflicted) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. I. Baumgartner		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 226 E. A. L. DER SP Address (Street, city, town, or county) OAKLAND - MD	
EXAMINER'S NAME (Type) E. I. Baumgartner, M.D.		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/15/66	23c. NAME OF CEMETERY OR CREMATORY Mt View	23d. LOCATION (City, town or county) (State) Moscow Mills, Md.
24. FUNERAL DIRECTOR E. J. Boal		25a. REC'D BY REGISTRAR Westernport, Md. 25b. REGISTRAR'S SIGNATURE Charles Judge DATE OCT 17 1966	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.

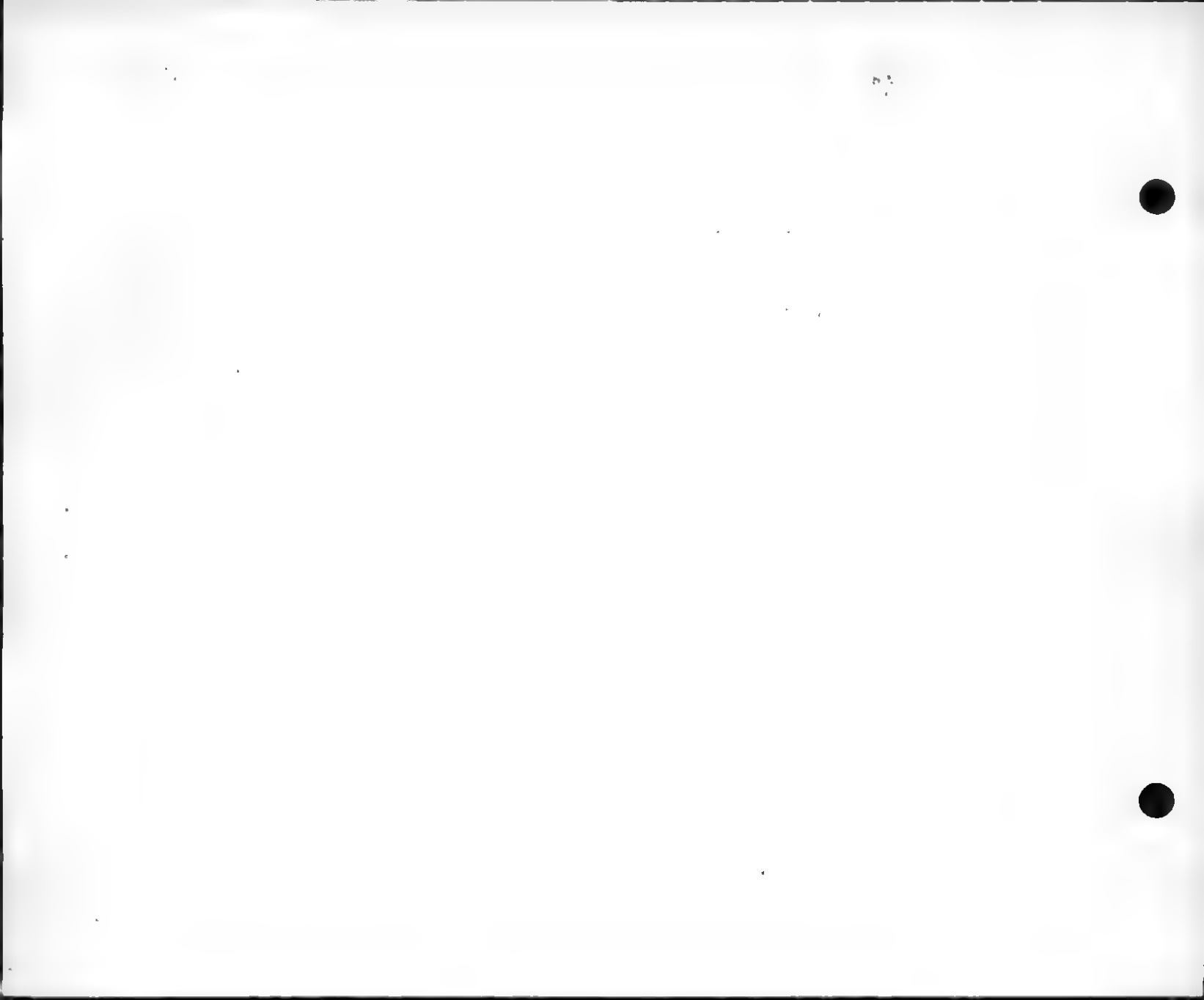
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14201

14201

1 PLACE OF DEATH a COUNTY <u>Garrett</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Garrett</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Oakland</u>		c LENGTH OF STAY IN 1b <u>D.C.A.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett Co. Mem. Hospital</u>		d STREET ADDRESS <u>Rt. 1</u>	
3 NAME OF DECEASED (Type or print) First <u>Oliver</u> Middle <u>Bliss</u> Last <u>Reams</u>		4 DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Caucasian</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 9, 1922</u>
9 AGE (In years last birthday) <u>74</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Bldg.</u>	
11 BIRTHPLACE (State or foreign country) <u>Swallow Falls, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Reams</u>		14 MOTHER'S MAIDEN NAME <u>Phila Lewis</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>220-16-5665</u>	
17 INFORMANT <u>Mrs. Cora Reams see #2 above</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Peripheral Vascular Collapse</u> T x L I DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Myocardial Infarct</u> DUE TO (c) <u>Arteriosclerotic Cardio-Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Min.</u> <u>5 Min.</u> <u>Unknown</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Herbert H. Leighton</u> M.D. EXAMINER'S NAME (Type) <u>Herbert H. Leighton, M.D.</u>		22. DATE SIGNED <u>9 Oct 66</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>10/12/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Taylor-Sines Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Garrett Co. Md.</u>	
24 FUNERAL DIRECTOR <u>Gerald D. Minnich</u>		25a REC'D BY REGISTRAR DATE <u>OCT 13 1966</u>	
ADDRESS <u>Oakland, Maryland</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in lieu of negative Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

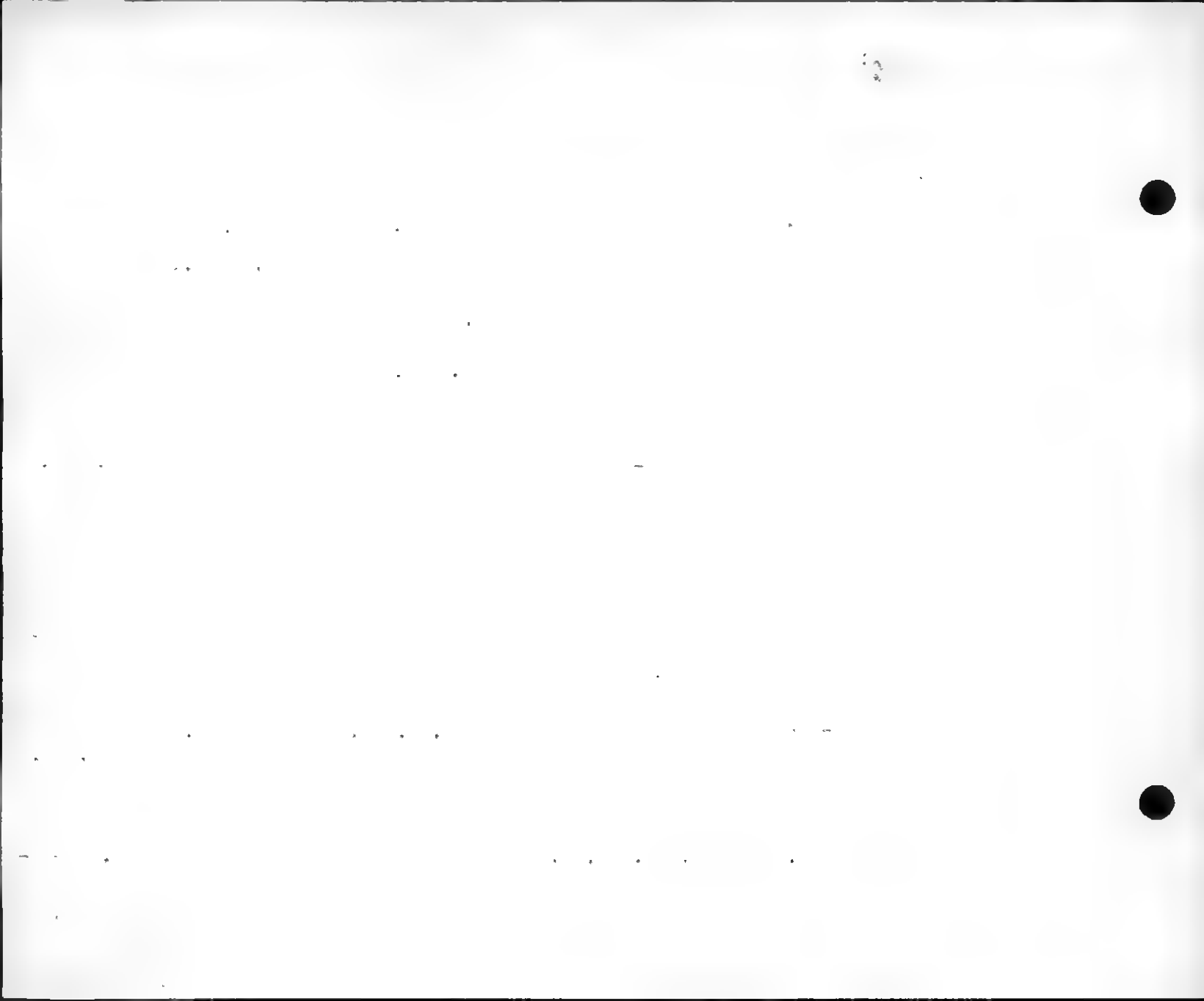
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN b Minutes		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Archie C Rosier		4. DATE OF DEATH Oct. 18th., 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 12, 1926
9. AGE (In years lost birthday) 40		10. IF UNDER 1 YEAR Months 16 Days 1 Hours 1 Min 1	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Rosier		14. MOTHER'S MAIDEN NAME Lona Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 232-36-6505	
17. INFORMANT Duda Funeral Home		Address Baltimore, Md.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 16.1 (c) 16.1		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driver of auto which s truck tractor trailer			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which s truck tractor trailer	
20c. TIME OF INJURY Month Day Year 7 10-18-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Highway		20f. (City or town) (County) (State) U. S. Rt. 50 (Rural) Mt. Storm Grant W. Va.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.		22. DATE SIGNED Oakland, Md. 10-18-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/66	
23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Gerald N. Merinich		25a. REC'D BY REG STRAR OCT 24 1966	
ADDRESS Oakland, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

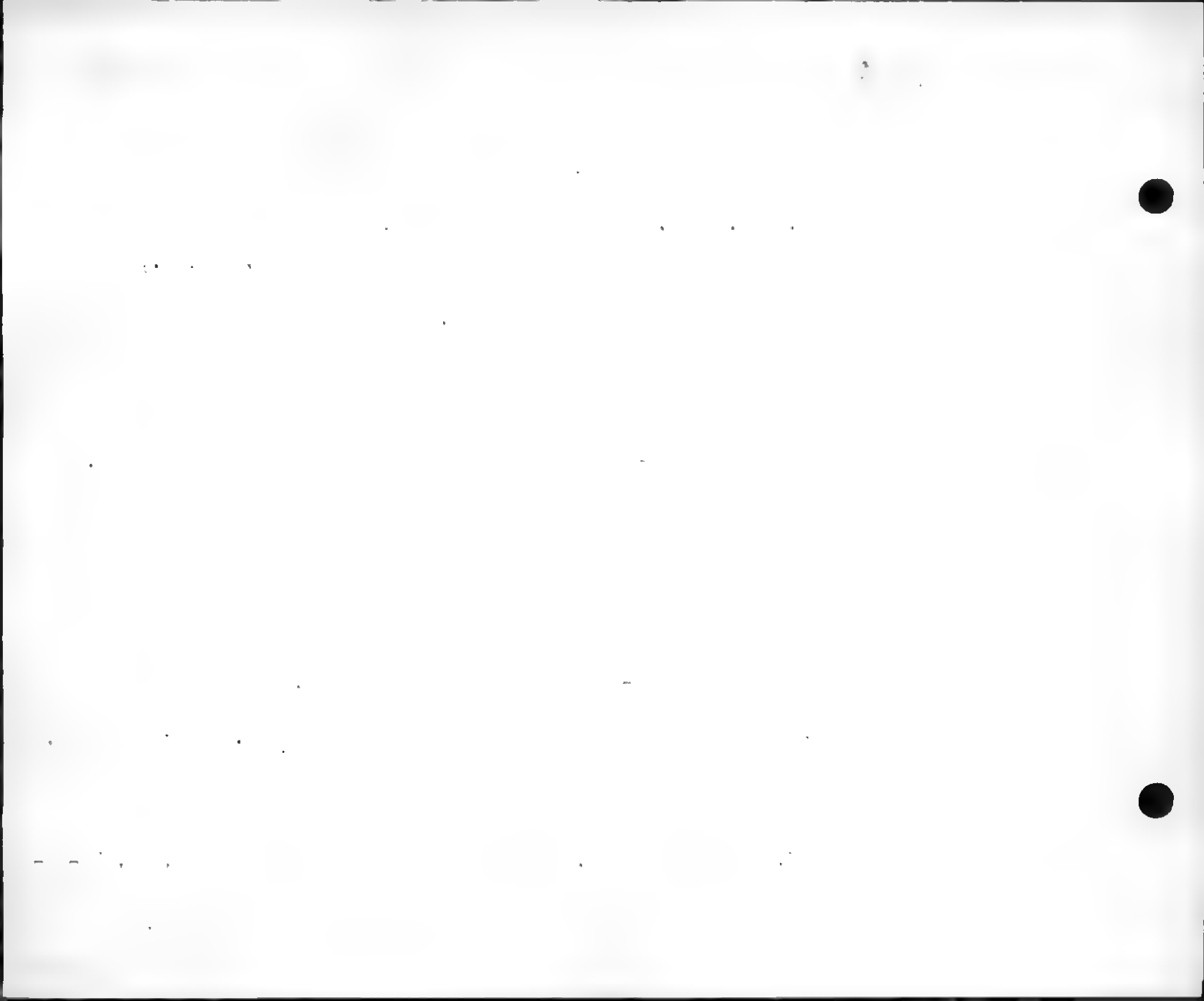
14203

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Garrett b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c LENGTH OF STAY IN 1b Minutes		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a STATE Maryland b COUNTY		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (DOA) Garrett Co. Mem. Hosp.				d STREET ADDRESS 4314 E. Lombard St.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Mickey Lee Rosier		4 DATE OF DEATH Oct. 18th., 1966		5 SEX Male		6 COLOR OR RACE White	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Oct. 4, 1952		9 AGE (In years last birthday) 14 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b KIND OF BUSINESS OR INDUSTRY School		11 BIRTHPLACE (State or foreign country) Maryland		12 COUNTRY OF WHAT COUNTRY? USA	
13 FATHER'S NAME Archie Rosier				14 MOTHER'S MAIDEN NAME Opal Sigley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO - - - -		17 INFORMANT Duda Funeral Home Baltimore, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 816.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) In auto-tractor trailer accident, U. S. Rt. 50					
20c TIME OF INJURY Month, Day, Year 7:00 am 10-18-66 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f (City or town) (County) (State) (Rural) Mt. Storm Grant W. Va.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		22. DATE SIGNED Oakland, Md. 10-18-66		Address (Street, city, town, or county)			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 10/24/66		23c NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR Gerald N. Minnich				25a REC'D BY REGISTRAR OCT 24 1966		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

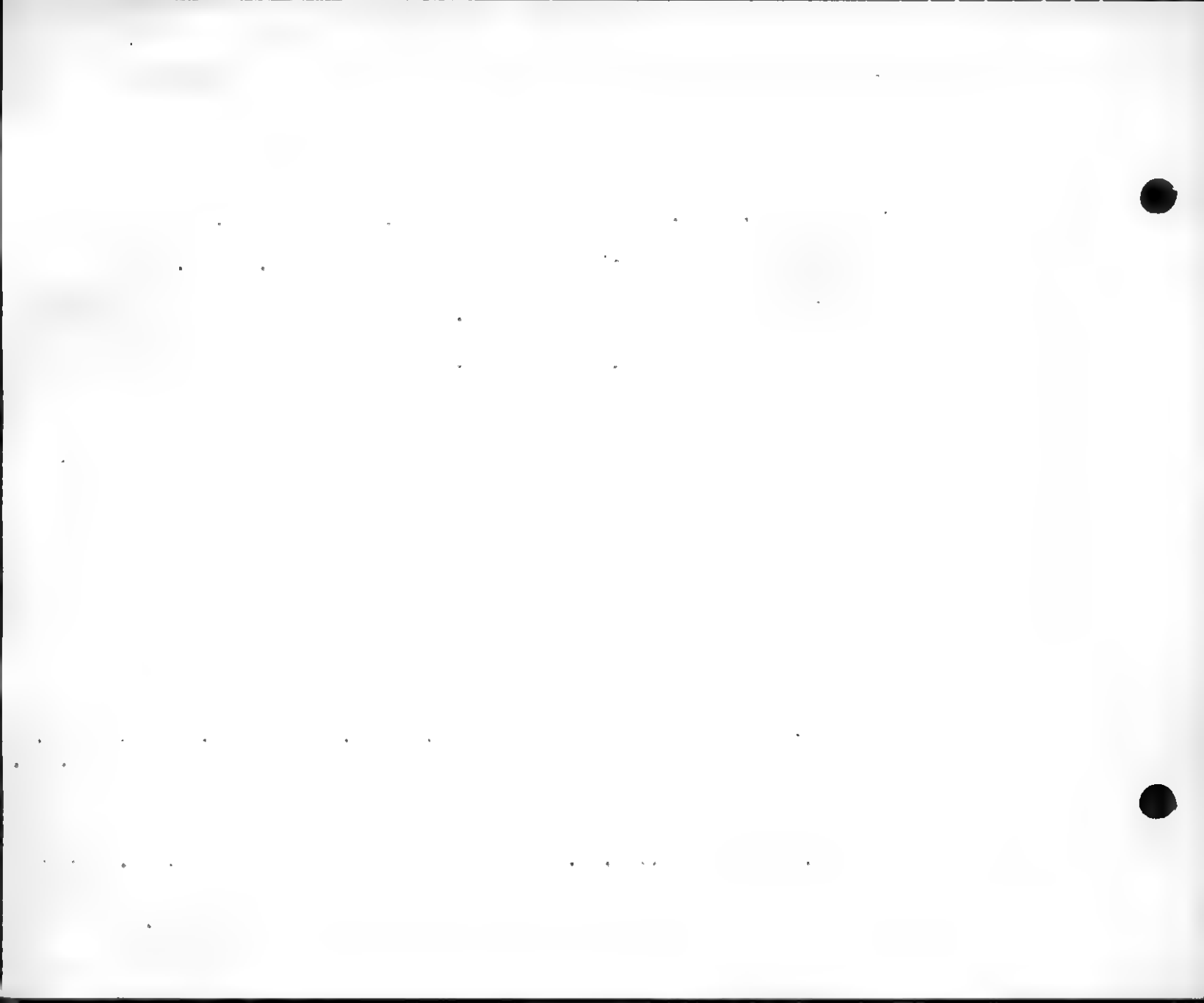
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14204

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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1 PLACE OF DEATH a COUNTY Garrett		2 USUAL RESIDENCE (Where deceased lived, institution, residence before admission) a STATE Maryland b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c LENGTH OF STAY IN 1b Minutes	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA) Garrett Co. Mem. Hosp.		e STREET ADDRESS 4314 E. Lombard St.	
3. NAME OF DECEASED (Type or print) Opal Marie Rosier		4. DATE OF DEATH Oct. 18th. 1966	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH Mar. 26, 1931
9 AGE (in years last birthday) 35		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b KIND OF BUSINESS OR INDUSTRY Rest.	
11 BIRTHPLACE (State or foreign country) W. Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Ray Sigley		14 MOTHER'S MAIDEN NAME Bessie Wilmouth	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 235-48-2734	
17 INFORMANT Duda Funeral Home		Address Baltimore, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN DEATH AND DEATH Minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Passenger in auto-tractor trailer accident	
20c. TIME OF INJURY Month, Day, Year 7 Hour 10-18-66	20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Highway, U. S. Rt. 50 (rural) Mt. Storm, Grant,	20f. (City or town) (County) (State) W. Va.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.		22. DATE SIGNED Oakland, Md. 10-18-66	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 10/24/66	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Gerald D. Minnich		25a. REC'D BY REGISTRAR OCT 24 1966	
ADDRESS Oakland, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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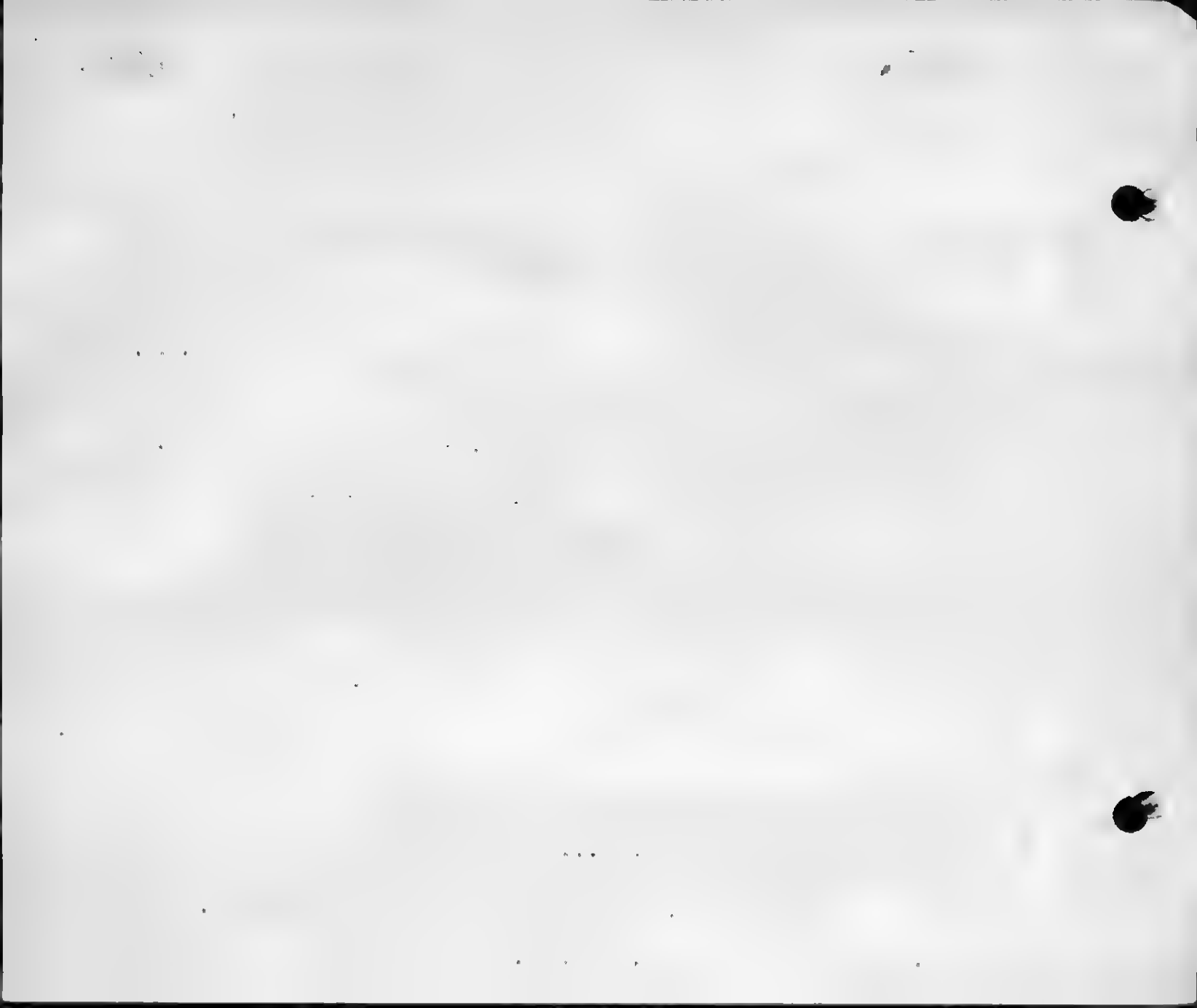
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

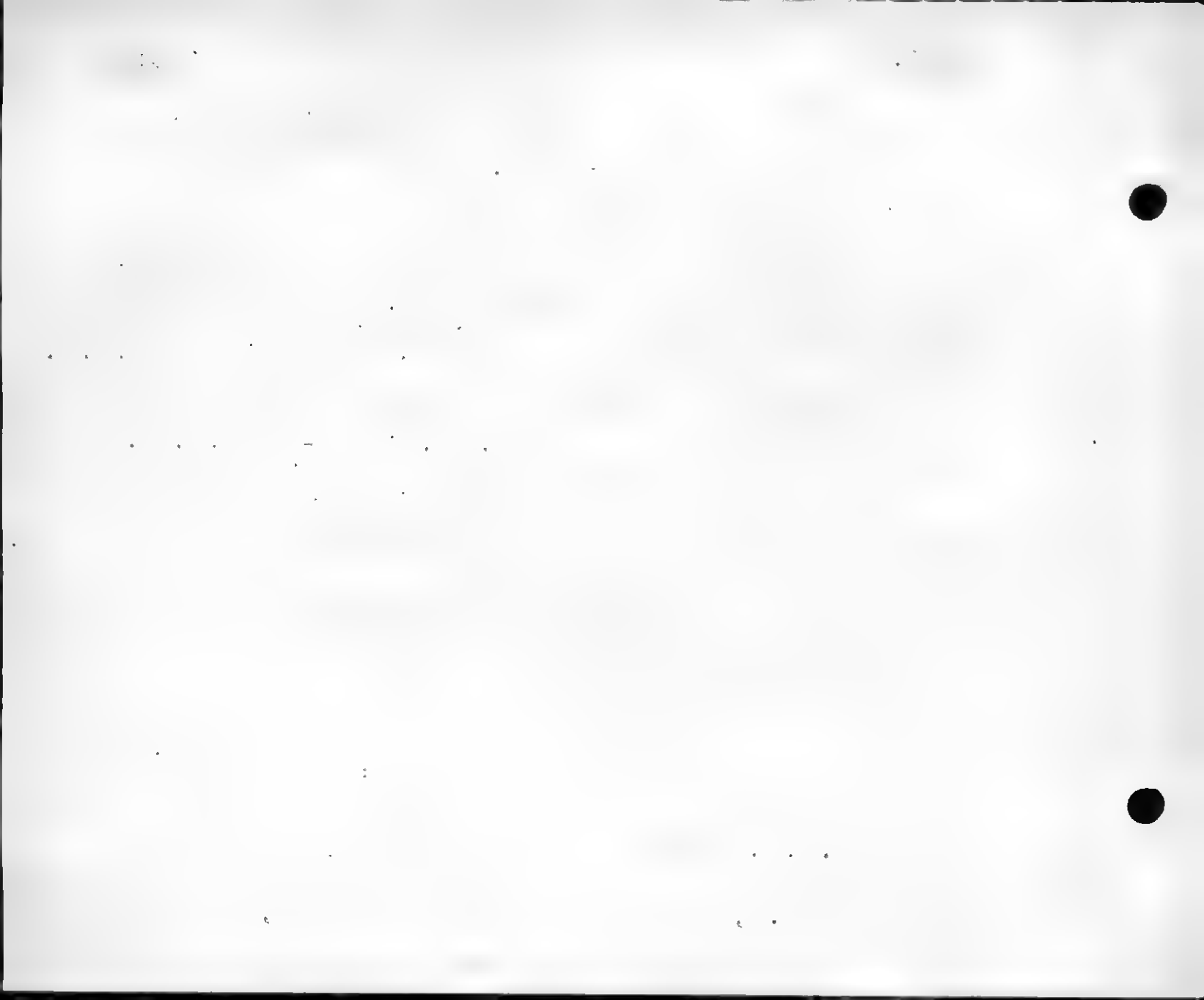
14205

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Frostburg</u> c. LENGTH OF STAY IN TB <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>9 Wells Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wifred Carl Simmons</u>		4. DATE OF DEATH Month Day Year <u>October 10 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/3/21</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>45</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Carl Simmons</u>		14. MOTHER'S MAIDEN NAME <u>Mamie DuVall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. 17. INFORMANT <u>Floyd W. Simmons</u> Address <u>Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Self Inflicted Bullets wounds of skull</u> DUE TO (b) <u>with destruction of frontals, temporals and occipital bones Destruction Brain tissue</u> DUE TO (c) <u>Result being shot by Jap 7.7 rifle</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted injuries Jap 7.7 rifle</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>Prob</u> p.m. <u>10/10/66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <u>Woods</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rural Frostburg Garrett Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10/12/66</u> Address (Street, city, town, or county)			
ACTUAL SIGNATURE <u>E. I. Baumgarther</u> EXAMINER'S NAME (Type) <u>E. I. Baumgarther, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>10/15/66</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u> ADDRESS <u>Philip B. Wendt 121 Memorial Ave. Cumb. Md.</u>	
22d. LOCATION (City, town, or country) (State) <u>Cumberland, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

DATE OCT 17 1966





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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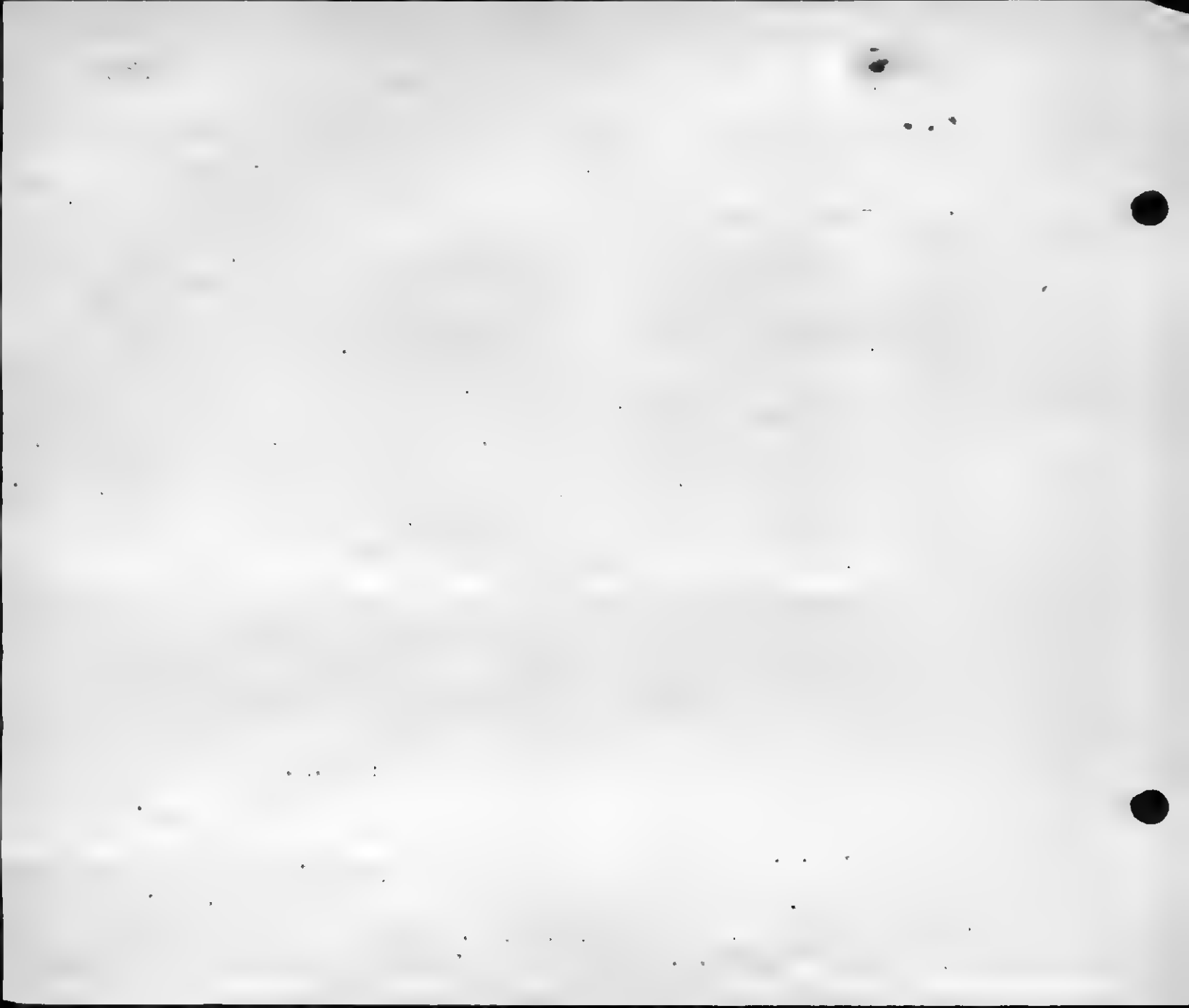
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14207

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Deer Park c. LENGTH OF STAY IN IL 6 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D. #1- (Eagle Rock)			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Kitzmiller d. STREET ADDRESS Short Run Community e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Cassie Victoria Susan Wilson			4. DATE OF DEATH Month Oct. Day 15 Year 19 66		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1882		9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR: Months 8 Days 4 IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Hezekiah Wilson			14. MOTHER'S MAIDEN NAME Mary Margaret Harvey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Mrs. Ruth Uppermen, R#1, Deer Park, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerosis 4500 DUE TO (b) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 4 yrs - 6-8 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 9:20 P.M. _____ causes and on the date stated above.					
22a. SIGNATURE A.E. Mance			22b. DATE SIGNED 16 Oct 66		
22c. PHYSICIAN'S NAME (Type) Dr. A.E. Mance			22d. ADDRESS Oakland, Md. 21550		
23a. BURIAL, CREMATION, or other disposition Burial	23b. DATE THEREOF Oct. 18/66	23c. NAME OF CEMETERY OR CREMATORY Short Run Cemetery	23d. LOCATION (City, town or county) Kitzmiller, Garrett Co., Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Blaine, W. Va. Kitzmiller, Md.			25a. REC'D BY REGISTRAR DATE OCT 24 1966		
			25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

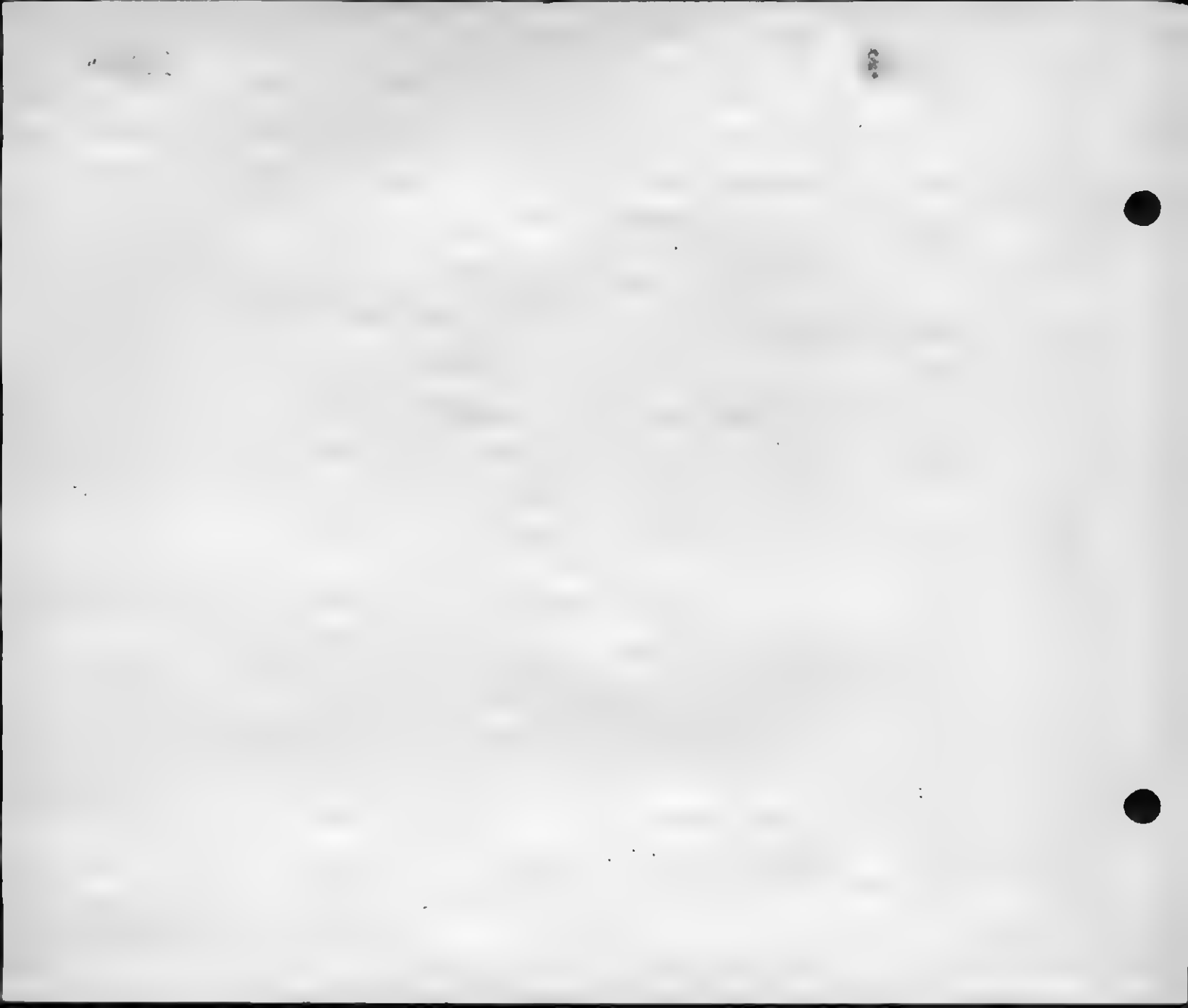
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14208

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kitzmiller</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kitzmiller</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Wendell</u> Middle <u>(nm)</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1966</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-3-1903</u> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General trucking</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Kitzmiller, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Paugh</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>			
16. SOCIAL SECURITY NO. <u>216-03-4604</u>				17. INFORMANT <u>Minnie P. Wilson</u> Address <u>Kitzmiller, MD</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Cerebral Heart Disease</u> DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>12 yr.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1965</u> to <u>Oct 12, 1966</u> that (I) (we) last saw the deceased alive on <u>Oct 10, 1966</u> and that death occurred at <u>3</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Ralph Colandrella</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>Oct 14, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ralph Colandrella</u>				22d. ADDRESS <u>Kitzmiller, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10-15-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Northen Hill Cemetery</u>				23d. LOCATION (City, town or county) <u>Elk Garden</u> (State) <u>W.Va.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert Kyle Pulla Jr.</u>				ADDRESS <u>Kitzmiller, MD.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>OCT 17 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

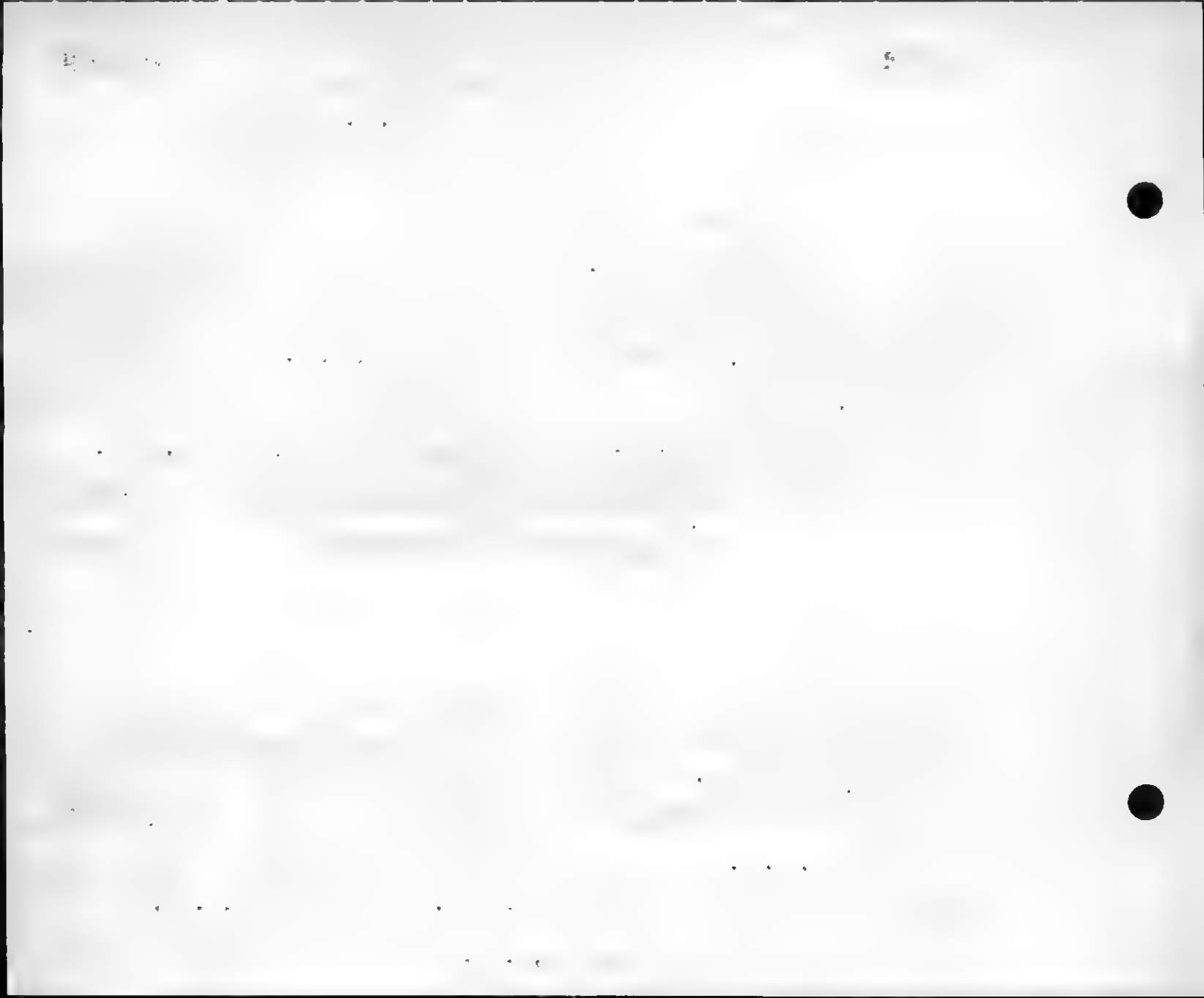


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be obtained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN lb 14 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett County Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W.Va. b. COUNTY Tucker c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thomas d. STREET ADDRESS Box 205 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alex Middle Jackson Last Wotring		4. DATE OF DEATH Month October Day 5 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 1, 1891 9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months 10 Days 24 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner Ret.		10b. KIND OF BUSINESS OR INDUSTRY Coal	
11. BIRTHPLACE (County & State, or foreign country) Location, W.Va.		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME John C. Wotring		14. MOTHER'S MAIDEN NAME Elizabeth Nestor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 232-03-1399	
17. INFORMANT Julia J. Wotring		Address Thomas, W.Va.	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arteriosclerosis DUE TO (c) 10 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/21 , 19 64 to Sept 1966 , that (I) (we) last saw the deceased alive on Oct. 5 , 19 66 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE A. E. Mance		22b. DATE SIGNED 6 Oct 66	
22c. PHYSICIAN'S NAME (Type) Dr. A. E. Mance		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/8/66	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION (City, town or county) (State) Thomas, W.Va.	
24. FUNERAL DIRECTOR Thomas, W.Va.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE OCT 10 1966	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14210					14210				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Garrett			a. STATE		Maryland		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Oakland			b. COUNTY		Garrett		
c. LENGTH OF STAY IN 1b		15 hrs. 5 mins.			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Oakland		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
Garrett County Memorial					301 Oakland Dr.				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First		Middle		Last		Month		Day Year	
Ernest		Sherman		Wotring		October 27,		19 66	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	August 31, 1885		81 yrs.		Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Plaster Contractor					Building		Aurora, W. Va.		U.S.A.
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
John Newton Wotring					Lydia King				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address		
No					214-16-2579		Robert Wotring, Oakland, Md. (Son)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chemia - Severe jaundice</i>									
5810 DUE TO (b) <i>Cirrhosis of Liver</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<i>Coronary Artery Disease - Advanced</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
19									
21. I certify that (I) (this hospital) attended the deceased from <i>March 1958</i> to <i>Oct 27, 1966</i> , that (I) (we) last saw the deceased alive on <i>Oct. 26, 1966</i> , and that death occurred at <i>12:35 AM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Robert H. Leighton</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>27 Oct 66</i>
22c. PHYSICIAN'S NAME (Type) Dr. H. H. Leighton					22d. ADDRESS Oakland, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (city, town or county) (State)			
Burial		10/29/66		Aurora Cemetery		Aurora, W. Va.			
24. FUNERAL DIRECTOR John O. Durst					25a. REC'D BY REGISTRAR <i>John O. Durst</i>		25b. REGISTRAR'S SIGNATURE <i>John O. Durst</i>		
Leighton-Durst Funeral Home, Oakland, Md.					DATE OCT 31 1966				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

14211

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14211

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) d. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, Md.		c. LENGTH OF STAY IN 1b 40 minutes	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		111	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett Co. Mem. Hospital		d. STREET ADDRESS 233 W. Liberty St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Harold Last Yutzy		4. DATE OF DEATH Month October Day 2nd. Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-09
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Business	
11. BIRTHPLACE (State or foreign country) Crellin, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Yutzy		14. MOTHER'S MAIDEN NAME Maude Sanders	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 235-22-4210	
17. INFORMANT Mrs. G. Harold Yutzy see # 2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular hemorrhage, massive 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. Years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Foaster, Jr., M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 10-2-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/66	
23c. NAME OF CEMETERY OR CREMATORY Garrett Co. Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Oakland, Maryland	
24. FUNERAL DIRECTOR Leuld A. Minnich ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR OCT 10 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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